North Dakota Century Code and North Dakota Administrative Code

26.1-18.1-12. Protection against insolvency.

1. Net worth requirements.

   a. Before issuing any certificate of authority, the commissioner shall require that the health maintenance organization have an initial net worth of one million dollars and shall thereafter maintain the minimum net worth required under subdivision b.

   b. Except as provided in subdivisions c and d, every health maintenance organization must maintain a minimum net worth equal to the greater of:

      (1) One million dollars;

      (2) Two percent of annual premium revenues as reported on the most recent annual financial statement filed with the commissioner on the first one hundred fifty million dollars of premium and one percent of annual premium on the premium in excess of one hundred fifty million dollars;

      (3) An amount equal to the sum of three months uncovered health care expenditures as reported on the most recent financial statement filed with the commissioner; or

      (4) An amount equal to the sum of:

         (a) Eight percent of annual health care expenditures except those paid on a capitated basis or managed hospital payment basis as reported on the most recent financial statement filed with the commissioner; and

         (b) Four percent of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement filed with the commissioner.

   c. A health maintenance organization licensed before August 1, 1993, and licensed only in this state must maintain the minimum requirements which are in effect at the time this chapter became law.

   d. (1) In determining net worth, no debt may be considered fully subordinated unless the subordination clause is in a form acceptable to the commissioner. Any interest obligation relating to the repayment of any subordinated debt must be similarly subordinated.

      (2) The interest expenses relating to the repayment of any fully subordinated debt must be considered covered expenses.

(3) Any debt incurred by a note meeting the requirements of this section, and otherwise acceptable to the commissioner, may not be considered a liability and must be recorded as equity.

2. Deposit requirements.
   a. Unless otherwise provided below, each health maintenance organization shall deposit with the commissioner or, at the discretion of the commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to the commissioner which at all times shall have a value of not less than three hundred thousand dollars.

   b. A health maintenance organization that is licensed only in this state and is in operation on August 1, 1993, shall make a deposit equal to one hundred thousand dollars.

   c. The deposit shall be an admitted asset of the health maintenance organization in the determination of net worth.

   d. All income from deposits is an asset of the organization. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value. Any securities must be approved by the commissioner before being deposited or substituted.

   e. The deposit must be used to protect the interests of the health maintenance organization's enrollees and to assure continuation of health care services to enrollees of a health maintenance organization that is in rehabilitation or conservation. The commissioner may use the deposit for administrative costs directly attributable to a receivership or liquidation. If the health maintenance organization is placed in receivership or liquidation, the deposit is an asset subject to the provisions of the liquidation act.

   f. The commissioner may reduce or eliminate the deposit requirement if the health maintenance organization deposits with the state treasurer, insurance commissioner, or other official body of the state or jurisdiction of domicile for the protection of all subscribers and enrollees, wherever located, of the health maintenance organization, cash, acceptable securities or surety, and delivers to the commissioner a certificate to the effect, duly authenticated by the appropriate state official holding the deposit.

3. Liabilities. Every health maintenance organization shall, when determining liabilities, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures which have been incurred, whether reported or unreported, which are unpaid and for which the organization is or may be liable, and to provide for the expense of adjustment or settlement of the claims. The liabilities must be computed in accordance with rules adopted by the commissioner upon reasonable

consideration of the ascertained experience and character of the health maintenance organization.

4. Hold harmless.

   a. Every contract between a health maintenance organization and a participating provider of health care services must be in writing and must set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee is not liable to the provider for any sums owed by the health maintenance organization.

   b. In the event that the participating provider contract has not been reduced to writing as required by this subsection or that the contract fails to contain the required prohibition, the participating provider may not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization.

   c. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization.

5. Continuation of benefits. The commissioner shall require that each health maintenance organization have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. In considering a plan, the commissioner may require:

   a. Insurance to cover the expenses to be paid for continued benefits after an insolvency.

   b. Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollee's discharge from inpatient facilities.

   c. Insolvency reserves.

   d. Acceptable letters of credit.

   e. Any other arrangements to assure that benefits are continued as specified above.

6. Notice of termination. An agreement to provide health care services between a provider and a health maintenance organization must require that if the provider terminates the agreement, the provider shall give the organization at least sixty days' advance notice of termination.

26.1-18.1-13. Uncovered expenditures insolvency deposit.

1. If at any time uncovered expenditures exceed ten percent of total health care expenditures, a health maintenance organization shall place an uncovered expenditures insolvency deposit with the commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is maintained, cash or securities that are acceptable to the commissioner. The deposit must at all times have a fair market value in an amount of one hundred twenty percent of the health maintenance organization's outstanding liability for uncovered expenditures for enrollees in this state, including incurred but not reported claims, and must be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within forty-five days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

2. The deposit required under this section is in addition to the deposit required under section 26.1-18.1-12 and is an admitted asset of the health maintenance organization in the determination of net worth. All income from the deposits or trust accounts is an asset of the health maintenance organization and may be withdrawn from the deposit or account quarterly with the approval of the commissioner.

3. A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if a substitute deposit of cash or securities of equal amount and value is made, the fair market value exceeds the amount of the required deposit, or the required deposit under subsection 1 is reduced or eliminated. Deposits, substitutions, or withdrawals may be made only with the prior written approval of the commissioner.

4. The deposit required under this section is in trust and may be used only as provided under this section. The commissioner may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment of claims of enrollees of this state for uncovered expenditures in this state. Claims for uncovered expenditures must be paid on a pro rata basis based on assets available to pay such ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining must be paid into the liquidation or receivership of the health maintenance organization.

5. The commissioner may by regulation prescribe the time, manner, and form for filing claims under subsection 4.

6. The commissioner may by rule or order require health maintenance organizations to file annual, quarterly, or more frequent reports as the commissioner deems necessary to demonstrate compliance with this section. The commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion.

26.1-18.1-14. Enrollment period and replacement coverage in the event of insolvency.

1. Enrollment period.

   a. In the event of an insolvency of a health maintenance organization, upon order of the commissioner all other carriers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer the group's enrollees of the insolvent health maintenance organization a thirty-day enrollment period commencing upon the date of insolvency. Each carrier shall offer the enrollees of the insolvent health maintenance organization the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

   b. If no other carrier had been offered to some groups enrolled in the insolvent health maintenance organization, or if the commissioner determines that the other health benefit plans lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group enrollees of the insolvent health maintenance organization, then the commissioner shall allocate equitably the insolvent health maintenance organization's group contracts for the groups among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are so allocated shall offer the group or groups the health maintenance organization's existing coverage which is most similar to each group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology.

   c. The commissioner shall also allocate equitably the insolvent health maintenance organization's nongroup enrollees which are unable to obtain other coverage among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall offer nongroup enrollees the health maintenance organization's existing coverage for individual or conversion coverage as determined by the type of coverage in the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology. Successor health maintenance organizations which do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes.

2. Replacement coverage.

   a. "Discontinuance" means the termination of the contract between the group contract holder and a health maintenance organization due to the insolvency of the health

maintenance organization, and does not refer to the termination of any agreement between any individual enrollee and the health maintenance organization.

b. Any carrier providing replacement coverage with respect to group hospital, medical, or surgical expense or service benefits within a period of sixty days from the date of discontinuance of a prior health maintenance organization contract or policy providing hospital, medical, or surgical expense or service benefits shall immediately cover all enrollees who were validly covered under the previous health maintenance organization contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active employment or hospital confinement or pregnancy.

c. Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract may be applied with respect to those enrollees validly covered under the prior carrier's contract or policy on the date of discontinuance.

45-06-13-04. Minimum net worth requirements. Prior to the issuance of a certificate of authority, a provider-sponsored organization must have a minimum net worth amount of:

1. At least one million five hundred thousand dollars except as provided in subsection 2.

2. No less than one million dollars based on evidence from the organization's financial plan demonstrating to the department's satisfaction that the organization has available to it an administrative infrastructure that the department considers appropriate to reduce, control, or eliminate startup administrative costs.

   a. After the effective date of a provider-sponsored organization's certificate of authority, a provider-sponsored organization shall maintain a minimum net worth amount equal to the greater of:

      (1) One million dollars;

      (2) Two percent of annual premium revenues as reported on the most recent annual financial statement filed with the department for up to and including the first one hundred fifty million dollars of annual premiums and one percent of annual premium revenues on premiums in excess of one hundred fifty million dollars;

      (3) An amount equal to the sum of three months of uncovered health care expenditures as reported on the most recent financial statement filed with the department; or

(4) Using the most recent annual financial statement filed with the department, an amount equal to the sum of:

(a) Eight percent of annual health care expenditures paid on a noncapitated basis to nonaffiliated providers;

(b) Four percent of annual health care expenditures paid on a capitated basis to nonaffiliated providers plus annual health care expenditures paid on a noncapitated basis to affiliated providers; and

(c) Annual health care expenditures that are paid on a capitated basis to affiliated providers are not included in the calculation of the net worth requirement under subsection 1 and this paragraph.

b. The minimum net worth amount shall be calculated as follows:

(1) Cash requirement:

(a) At the time of the application for a certificate of authority, the provider-sponsored organization shall maintain at least seven hundred fifty thousand dollars of the minimum net worth amount in cash or cash equivalents.

(b) After the effective date of a provider-sponsored organization's certificate of authority, a provider-sponsored organization shall maintain the greater of seven hundred fifty thousand dollars or forty percent of the minimum net worth amount in cash or cash equivalents.

(2) Intangible assets. An organization may include intangible assets, the value of which is based on generally accepted accounting principles, in the minimum net worth amount calculation subject to the following limitations:

(a) At the time of application:

(i) Up to twenty percent of the minimum net worth amount, provided at least one million dollars of the minimum net worth amount is met through cash or cash equivalents; or
(ii) Up to ten percent of the minimum net worth amount, if less than one million dollars of the minimum net worth is met through cash or cash equivalents, or if the department has used its discretion under this subsection.

(b) From the effective date of the provider-sponsored organization's certificate of authority:

(i) Up to twenty percent of the minimum net worth amount if the greater of one million dollars or sixty-seven percent of the minimum net worth is met by cash or cash equivalents; or

(ii) Up to ten percent of the minimum net worth amount if the greater of one million dollars or sixty-seven percent of the minimum net worth amount is not met by cash or cash equivalents.

(3) Health care delivery assets. Subject to the other provisions of this section, a provider-sponsored organization may apply one hundred percent of the generally accepted accounting principles depreciated value of health care delivery assets to satisfy the minimum net worth amount.

(4) Other assets. A provider-sponsored organization may apply other assets not used in the delivery care provided that those assets are valued according to statutory accounting practices as defined by the department.

(5) Subordinated debts and subordinated liabilities. Fully subordinated debt and subordinated liabilities are excluded from the minimum net worth amount calculation.

(6) Deferred acquisition costs. Deferred acquisition costs are excluded from the calculation of the minimum net worth amount.

History
History: Effective August 1, 2000.
General authority
General Authority: NDCC 26.1-01-07.6
Law implemented
Law Implemented: NDCC 26.1-01-07.6

45-06-13-05. Financial plan requirements

1. General rule. At the time of application under section 45-06-13-03, an applicant must submit a financial plan acceptable to the department.

2. A financial plan must include:

   a. A detailed marketing plan;

   b. Statements of revenue and expense on an accrual basis;

   c. Statements of sources and uses of funds;

d. Balance sheets;

e. Detailed justifications and assumptions in support of the financial plan including, when appropriate, certification of reserves and actuarial liabilities by a qualified health maintenance organization actuary; and

f. If applicable, statements of the availability of financial resources to meet projected losses.

3. Period covered by the plan. A financial plan shall:

a. Cover the first twelve months after the estimated effective date of a provider-sponsored organization's medicare+choice contract; or

b. If the provider-sponsored organization is projecting losses, cover twelve months beyond the end of the period for which losses are projected.

4. Funding for projected losses. Except for the use of guarantees, letters of credit, and other means as provided in section 45-06-13-08, an organization shall have the resources for meeting projected losses on its balance sheet in cash or a form that is convertible to cash in a timely manner, in accordance with the provider-sponsored organization's financial plan.

5. Guarantees and projected losses. Guarantees will be an acceptable resource to fund projected losses, provided that a provider-sponsored organization:

a. Meets the department's requirements for guarantors and guarantee documents as specified in section 45-06-13-08; and

b. Obtains from the guarantor cash or cash equivalents to fund the projected losses timely, as follows:

(1) Prior to the effective date of a provider-sponsored organization's medicare+choice contract, the amount of the projected losses for the first two quarters;

(2) During the first quarter and prior to the beginning of the second quarter of a provider-sponsored organization's medicare+choice contract, the amount of projected losses through the end of the third quarter; and

(3) During the second quarter and prior to the beginning of the third quarter of a provider-sponsored organization's medicare+choice contract, the amount of projected losses through the end of the fourth quarter.

c. If the guarantor complies with the requirements in subdivision b, the provider-sponsored organization, in the third quarter, may notify the department of its intent to reduce the period of advance funding of projected losses. The department shall notify the provider-

sponsored organization within sixty days of receiving the provider-sponsored organization's request if the requested reduction in the period of advance funding will not be accepted.

d. If the guarantee requirements in subdivision b are not met, the department may take appropriate action, such as requiring funding of projected losses through means other than a guarantee. The department retains discretion to require other methods or timing of funding, considering factors such as the financial condition of the guarantor and the accuracy of the financial plan.

6. Letters of credit. Letters of credit are an acceptable resource to fund projected losses, provided they are irrevocable, unconditional, and satisfactory to the department. They shall be capable of being promptly paid upon presentation of a sight draft under the letters of credit without further reference to any other agreement, document, or entity.

7. Other means. If satisfactory to the department, and for periods beginning one year after the effective date of a provider-sponsored organization's medicare+choice contract, a provider-sponsored organization may use the following to fund projected losses:

   a. Lines of credit from regulated financial institutions;

   b. Legally binding agreements for capital contributions; or

   c. Legally binding agreements of a similar quality and reliability as permitted in subdivisions a and b.

8. Application of guarantees, letters of credit, or other means of funding projected losses. Notwithstanding any other provision of this section, a provider-sponsored organization may use guarantees, letters of credit, and, beginning one year after the effective date of a provider-sponsored organization's medicare+choice contract, other means of funding projected losses, but only in a combination or sequence that the department considers appropriate.

History
History: Effective August 1, 2000.
General authority
General Authority: NDCC 26.1-01-07.6
Law implemented
Law Implemented: NDCC 26.1-01-07.6

45-06-13-06. Liquidity

1. A provider-sponsored organization shall have sufficient cash flow to meet its financial obligations as they become due and payable.

2. To determine whether the provider-sponsored organization meets the requirement in subsection 1, the department will examine the following:

   a. The provider-sponsored organization's timeliness in meeting current obligations;

   b. The extent to which the provider-sponsored organization's current ratio of assets to liabilities is maintained at a one to one ratio including whether there is a declining trend in the current ratio over time; and

   c. The availability of outside financial resources to the provider-sponsored organization.

3. If the department determines that a provider-sponsored organization fails to meet the requirement in subdivision a of subsection 2, the department will require the provider-sponsored organization to initiate corrective action and pay all overdue obligations.
4. If the department determines that a provider-sponsored organization fails to meet the requirement of subdivision b of subsection 2, the department will require the provider-sponsored organization to initiate corrective action to:

   a. Change the distribution of its assets;

   b. Reduce its liabilities; or

   c. Make alternative arrangements to secure additional funding to restore the provider-sponsored organization's current ratio to one to one.

5. If the department determines that a provider-sponsored organization fails to meet the requirement of subdivision c of subsection 2, the department will require the provider-sponsored organization to obtain funding from alternative financial resources.

History
History: Effective August 1, 2000.
General authority
General Authority: NDCC 26.1-01-07.6
Law implemented
Law Implemented: NDCC 26.1-01-07.6

45-06-13-07. Deposits

1. Insolvency deposit.

   a. At the time of application, an organization shall deposit one hundred thousand dollars in cash or securities, or any combination thereof, into an account in a manner that is acceptable to the department.

b. The deposit must be restricted to use in the event of insolvency to help assure continuation of services or pay costs associated with receivership or liquidation.

c. At the time of the provider-sponsored organization's application for a certification of authority, and, thereafter, upon the department's request, a provider-sponsored organization shall provide the department with proof of the insolvency deposit, such proof to be in a form that the department considers appropriate.

2. Uncovered expenditures deposit.

a. If at any time uncovered expenditures exceed ten percent of a provider-sponsored organization's total health care expenditures, then the provider-sponsored organization must place an uncovered expenditures deposit into an account with any organization or trustee that is acceptable to the department.

b. The deposit must at all times have fair market value of an amount that is one hundred twenty percent of the provider-sponsored organization's outstanding liability for uncovered expenditures for enrollees, including incurred, but not reported, claims.

c. The deposit must be calculated as of the first day of each month required and maintained for the remainder of each month required.

d. If a provider-sponsored organization is not otherwise required to file a quarterly report, it must file a report within forty-five days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

e. The deposit required under this section is restricted and in trust for the department's use to protect the interests of the provider-sponsored organization's Medicare enrollees and to pay the costs associated with administering the insolvency. It may be used only as provided under this section.

3. Deposit as asset. A provider-sponsored organization may use the deposits required under subsections 1 and 2 to satisfy the provider-sponsored organization's minimum net worth amount required under section 45-06-13-04.

4. Income. All income from the deposits or trust accounts required under subsections 1 and 2 is considered assets of the provider-sponsored organization. Upon the department's approval, the income from the deposits may be withdrawn.

5. Withdrawal. On prior written approval from the department, a provider-sponsored organization that has made a deposit under subsection 1 or 2 may withdraw that deposit or any part thereof if:

a. A substitute deposit of cash or securities of equal amount and value is made;

b. The fair market value exceeds the amount of the required deposit; or

c. The required deposit under subsection 1 or 2 is reduced or eliminated.

History
History: Effective August 1, 2000.
General authority
General Authority: NDCC 26.1-01-07.6
Law implemented
Law Implemented: NDCC 26.1-01-07.6

45-06-13-08. Guarantees

1. General policy. A provider-sponsored organization, or the legal entity of which the provider-sponsored organization is a component, may apply to the department to use the financial resources of a guarantor for the purpose of meeting the requirements in section 45-06-13-05. The department has the discretion to approve or deny approval of the use of a guarantor.

2. Request to use a guarantor. To apply to use the financial resources of a guarantor, a provider-sponsored organization must submit to the department the following material:

   a. Documentation that the guarantor meets the requirements for a guarantor under subsection 3; and

   b. The guarantor's independently audited financial statements for the current year-to-date and for the two most recent fiscal years. The financial statements must include the guarantor's balance sheets, the profit and loss statements, and cash flow statements.

3. Requirements for guarantor. To serve as a guarantor, an organization must meet the following requirements:

   a. Be a legal entity authorized to conduct business within a state of the United States.

   b. Not be under federal or state bankruptcy or rehabilitation proceedings.

   c. Have a net worth, not including other guarantees, intangibles, and restricted reserves, equal to three times the amount of the provider-sponsored organization guarantee.

   d. If the guarantor is regulated by a state insurance commissioner, or other state official with authority for risk-bearing entities, it must meet the net worth requirement in subdivision c with all guarantees and all investments in and loans to organizations covered by guarantees excluded from its assets.

e. If the guarantor is not regulated by a state insurance commissioner or other similar state official, it must meet the net worth requirement in subdivision c with all guarantees and all investments in and loans to organizations covered by a guarantee and to related parties, subsidiaries, and affiliates excluded from its assets.

4. Guarantee document. If the guarantee request is approved, a provider-sponsored organization must submit to the department a written guarantee document signed by an appropriate authority of the guarantor. The guarantee document must contain the following provisions:

   a. State the financial obligation covered by the guarantee;

   b. Agree to unconditionally fulfill the financial obligation covered by the guarantee;

   c. Agree not to subordinate the guarantee to any other claim on the resources of the guarantor;

   d. Declare that the guarantor must act on a timely basis, in any case not more than five business days, to satisfy the financial obligation covered by the guarantee; and

   e. Meet other conditions as the department may establish from time to time.

5. Reporting requirement. A provider-sponsored organization shall submit to the department the current internal financial statements and annual financial statements of the guarantor according to the schedule, manner, and form that the department requests.

6. Modification, substitution, and termination of a guarantee. A provider-sponsored organization may not modify, substitute, or terminate a guarantee unless the provider-sponsored organization:

   a. Requests the department's approval at least ninety days before the proposed effective date of the modification, substitution, or termination;

   b. Demonstrates to the department's satisfaction that the modification, substitution, or termination will not result in insolvency of the provider-sponsored organization; and

   c. Demonstrates how the provider-sponsored organization will meet the requirements of this section.

7. Nullification. If at any time the guarantor or the guarantee ceases to meet the requirements of this section, the department shall notify the provider-sponsored organization that it ceases to recognize the guarantee document. In the event of this nullification, a provider-sponsored organization shall:

a. Meet the applicable requirements of this section within fifteen business days; and

b. If required by the department, meet a portion of the applicable requirements in less than the time period granted in subdivision a.

History
History: Effective August 1, 2000.
General authority
General Authority: NDCC 26.1-01-07.6
Law implemented
Law Implemented: NDCC 26.1-01-07.6

26.1-12-08. License required - Prerequisites to issuance of license. A mutual insurance company organized under this chapter may not issue policies or transact any insurance business unless it holds a license from the commissioner authorizing the transaction of insurance business. The license may not be issued unless and until the company complies with the following conditions:

1. It must hold bona fide applications for insurance upon which it will issue simultaneously at least twenty policies to at least twenty members for the same kind of insurance upon not less than two hundred separate risks, each within the maximum single risk.

2. It must have collected a premium upon each application. All premiums must be held in cash or in securities in which insurance companies may invest, and in the case of fire insurance, must be equal to not less than twice the maximum single risk assumed subject to one fire nor less than ten thousand dollars, and in any other kind of insurance as listed in section 26.1-12-11, to not less than five times the maximum single risk assumed nor less than ten thousand dollars.

3. It must maintain a surplus of at least one million dollars. However, for any company doing business only in this state, if the minimum assets and surplus requirements required by this subsection are more than the minimum requirements at the time the company was issued its original certificate of authority to do business, the company may maintain assets and surplus which satisfy the requirements in effect at that time. For all other companies, if the minimum assets and surplus requirements required by this subsection are more than the minimum requirements required at the time the company was issued its original certificate of authority, the company shall increase its surplus of assets over all liabilities according to the following schedule:

   a. Two hundred fifty thousand dollars by December 31, 1994.

   b. Five hundred thousand dollars by December 31, 1995.

   c. Seven hundred fifty thousand dollars by December 31, 1996.

d. One million dollars by December 31, 1997.

CHAPTER 26.1-03.2 RISK-BASED CAPITAL FOR HEALTH ORGANIZATIONS

26.1-03.2-01. Definitions. In this chapter, unless the context or subject matter otherwise requires:

5. "Health organization" means a health maintenance organization, prepaid limited health service organization, nonprofit health service corporation, or other managed care organization licensed by the commissioner to do business in this state. "Health organization" does not include an organization that is licensed as either a life and health insurer or a property and casualty insurer that is otherwise subject to either the life or property and casualty risk-based capital requirements.

6. "Risk-based capital instructions" means the risk-based capital report including risk-based capital instructions adopted by the national association of insurance commissioners, as these risk-based capital instructions may be amended by the national association of insurance commissioners from time to time in accordance with the procedures adopted by the national association of insurance commissioners.

7. "Risk-based capital level" means a health organization's company action level risk-based capital, regulatory action level risk-based capital, authorized control level risk-based capital, or mandatory control level risk-based capital and:

   a. "Authorized control level risk-based capital" means the number determined under the risk-based capital formula in accordance with the risk-based capital instructions.

   b. "Company action level risk-based capital" means, with respect to any health organization, the product of 2.0 and its authorized control level risk-based capital.

   c. "Mandatory control level risk-based capital" means the product of .70 and the authorized control level risk-based capital.

   d. "Regulatory action level risk-based capital" means the product of 1.5 and its authorized control level risk-based capital.

26.1-03.2-02. Risk-based capital reports.

1. On or before each March first, a domestic health organization shall prepare and submit to the commissioner a report of its risk-based capital levels as of the end of the calendar year just ended, in a form and containing such information as is required by the risk-based capital instructions. In addition, a domestic health organization shall file its risk-based capital report:

   a. With the national association of insurance commissioners in accordance with the risk-based capital instructions; and

b. With the insurance commissioner in any state in which the health organization is authorized to do business, if the insurance commissioner has notified the health organization of its request in writing, in which case the health organization shall file its risk-based capital report not later than the latter of:

(1) Fifteen days from the receipt of notice to file its risk-based capital report with that state; or

(2) The filing date.

2. A health organization's risk-based capital must be determined in accordance with the formula set forth in the risk-based capital instructions. The formula must take the following into account, and may adjust for the covariance between, as determined in each case by applying the factors in the manner set forth in the risk-based capital instructions:

a. Asset risk;

b. Credit risk;

c. Underwriting risk; and

d. All other business risks and such other relevant risks as are set forth in the risk-based capital instructions.

3. Net worth over the amount produced by the risk-based capital requirements contained in this chapter and the formulas, schedules, and instructions referenced in this chapter is desirable in the business of health insurance. Accordingly, health organizations should seek to maintain capital above the risk-based capital levels required by this chapter. Additional capital is used and useful in the insurance business and helps to secure a health organization against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this chapter.